is to be controlled in this high risk population.

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Same day testing for HIV: 1 year's experience in a district general hospital and at an alternative site

In the Department of Health's white paper, the *Health of the Nation*[1] sexual health, including HIV and AIDS, is identified as one of the key areas of health targeting. Counselling and screening for HIV forms an important part of sexual health and this service should be widely available. Experience suggests, as stated in *HIV/AIDS and Sexual Health*,[2] that where available many would prefer to attend a clinic separate from current services. In response to the executive letter from the Department of Health,[3] a same day HIV counselling and testing service was developed at Bolton General Hospital, and at an alternative site in the town centre. We present the results of this service over a 12 month period.

In May 1994, a same day testing service was introduced in addition to the routine clinic testing, available 1 day a week by appointment only, both in the hospital department and also at an alternative (town centre) site. The same day service was advertised locally. All patients attending for HIV testing were given pre- and post-test counselling and sexual health advice at both sites.

Over the 12 month period, 218 patients made appointments for same day HIV antibody testing. The default rate for the same day testing service was 22·5% (n = 49). The same day hospital site had a higher attendance rate than the alternative site (table). There was one positive HIV antibody result in a homosexual man who was asymptomatic. Six patients requested testing because of a possible risk of HIV infection from overseas medical treatment. All of these opted to be tested at the clinic site, their choice perhaps reflecting concerns which they felt might be better addressed in a hospital setting. Same day testing accounted for 41·8% of the total number of HIV tests within the department.

Predominant risk factors and default rates for patients tested at the same day testing sites

	Clinic site (n = 94)	*Alternative site (n = 65)*
Default rate	22·3% (n = 27)	25·3% (n = 22)
Male	60	39
Female	34	26
Homosexual	9	14
Heterosexual	62	38
Bisexual	2	1
Intravenous drugs	9	9
Overseas medical treatment	6	0
Others, for example, occupational	6	3

The current arrangement for HIV antibody testing in genitourinary medicine clinics within the hospital setting has the advantage that the service is widely available and testing is performed in an anonymous and confidential manner. This testing service may have its drawbacks for certain patients who find attending a genitourinary medicine clinic a daunting prospect, especially if the department is based inside a large hospital which is not readily accessible from the local town centre. Other authors have reported successful same day testing services within city centres[4]; however, this is the first paper to report results from a district general hospital setting together with the use of an alternative site. Our results show that a significant proportion of patients opted for the same day testing service and when given the choice of site, patients were more likely to attend the same day hospital service than the alternative site. Further work is required to ascertain reasons behind the high default rate of patients requesting same day HIV testing, as little is known about the sociodemographic details and risk factors among this group. Future evaluation should include qualitative feedback from patients on the issues surrounding testing to determine the optimal testing procedure and site.

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Survival and treatment of AIDS patients 1984–1993

Hillman *et al* seem somewhat confused with their contribution to the debate regarding the place and value of HIV service provision and whether this should be through larger or smaller centres.[1] Assessing survival from AIDS is not a measure of quality of service. Indeed, survival from AIDS may decrease but quality of life and overall survival from HIV infection may be improved.[2] We have shown previously in a study involving a large number of patients that survival from AIDS may be influenced by the time of presentation—that is, that survival may increase if the AIDS defining illness occurs coincident with the first positive HIV antibody test.[3] This does not mean, as Hillman *et al* assert, that we are questioning the benefit of medical intervention—quite the reverse. We propose that the development of AIDS has been delayed by medical intervention. Indeed, in their paper Hillman *et al* support the assertion that effective intervention may reduce survival from AIDS; they saw a reduction in median survival over time in their patients.

Furthermore, the authors suggest that in our study we both failed to acknowledge improvements in survival made before the study period from St Mary's Hospital and did not adjust for case mix in the two arms.[3] In fact, earlier data were acknowledged and referenced and the case mix of the two arms was described in detail.

Hillman *et al* conclude in their paper that smaller units may allow a more informal and intimate setting for patients to be treated. This, however, is not supported by their data and is, therefore, only an unsubstantiated opinion. Others, we are sure, would argue against it.

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MATTERS ARISING

Who goes to sexually transmitted diseases clinics? Results from a national population survey (*Genitourin Med* 1996;72:197–202)

We read with great interest Dr A M Johnson and colleagues' sexual behaviour survey of GUM clinic attenders, published in *Genitourin Med*. The findings of the study now make available good population based data on the characteristics of genitourinary medicine clinic attenders, which will be applicable to many aspects of further research and service planning.

However, we wish to comment on one point made by the authors, in respect of data from GUM clinics being recorded on diagnostic cases rather than on individuals. It may not be widely known that, since April

1995, this problem has been rectified in data from Scottish GUM clinics. Scotland is now in a unique position in the UK, in that we now collect statistics on individuals (with all due attention to preserving anonymity, by using unique identifiers), rather than diagnostic events. These changes have been introduced in tandem with a major review of case definitions and more clinically relevant coding categories.

Our data can now be linked to both demographic and sexual behaviour data, as well as to a clearly definable denominator population. To this end, therefore, the deficiencies to which the authors refer in their paper will no longer apply in Scotland. We are shortly due to commence a local study of sexual behaviour in GUM clinic attenders in Glasgow compared with a control population (in a nearby family planning centre) and we hope that many similar developments will be possible in the future, as a result of this fundamental improvement in the methodology of our data collection.

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Urinary symptoms, sexual intercourse and significant bacteriuria in male patients attending STD clinics

We read with interest the recent paper by David *et al*[1] on urinary symptoms and bacteriuria among male STD clinic attenders. The authors state that *urethritis and UTI cannot be distinguished on clinical grounds and/or urethral smears*. We were surprised that no mention was made of the "two glass urine test" as a means of distinguishing pure urethritis from a combined urethritis/cystitis. We find this a useful test—from January to July this year 11 men attended our department with a documented UTI; nine of these had a cloudy second catch urine (not due to phosphaturia). We would, therefore, be interested to hear whether the authors can provide details of the two glass urine test results in their patients with both bacteriuric and non-bacteriuric urinary symptoms.

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1 David LM, Natin D, Walzman M, Stocker D. Urinary symptoms, sexual intercourse and significant bacteriuria in male patients attending STD clinics. *Genitourin Med* 1996; 72:266–8.

The authors reply:

Although the "two glass urine test" is a time honoured practical in house clinic test, we did not include it in our study. This test in our opinion is subject to observational variation and interpretation. We think that looking under the microscope for quantitative assessment of inflammatory cells is less subject to observer variation and is more scientific. In the Cambridge group only nine of the 11 patients with urinary tract infections had a cloudy second urine, while all the 13 patients with urinary tract infection in our study were found to have pyuria.

LOAY DAVID
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Antibiotic treatment for gonorrhoea in the UK

The emergence of resistance to quinolones in *Neisseria gonorrhoeae* was highlighted in the review by Ison[1] and in the report by Abeyewickereme and others.[2] However, in the UK quinolones are becoming ever more widely used and have now overtaken penicillin as the drug of first choice. The National Audit of gonorrhoea management questioned all clinics in the UK about cases diagnosed in the first three months of 1995 and received data on 1308 cases, 59% of all reported in the quarter. The antibiotics used fell into the following classes: quinolones 48%, penicillins 40%, spectinomycin 3%, others/not recorded 9%. For those patients known to have acquired their infection outside Europe, and when penicillinase producing *Neisseria gonorrhoeae* (PPNG) was presumably thought to be more likely, the choice (ignoring single use and unspecified drugs) was: quinolones 73%, penicillins 23%, spectinomycin 4%.

Ciprofloxacin resistance is still rare in the UK, but in 1995 the highest ever annual total of ciprofloxacin resistant strains was identified by the Gonococcus Reference Unit, while PPNG isolates were still below their 1992 figure.[3] The Reference Unit data rely on voluntary reporting with its attendant limitations. The National Audit figures show that antibiotic choice has moved away from penicillins, so it is now particularly important that information monitoring the extent of ciprofloxacin resistance is available to UK genitourinary physicians.

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Epidemiology of gonococcal and chlamydial infections in Harrow and Brent

Matondo and colleagues report on gonococcal and chlamydial infections in Harrow and Brent.[1] I would agree that it is important to perform such work since it can define "the extent of the problem in the community" and allow for the development of "a profile of STDs in our catchment population".

Sadly, they have done neither of these two since their sampling is limited solely to those using the genitourinary medicine (GUM) clinic at Northwick Park. An earlier study (not mentioned by the authors), also carried out in Brent and Harrow, was able to do both of these.[2] This study was conducted to identify and estimate the proportion of female patients suffering from gonorrhoea, trichomoniasis and candidosis, both with and without symptoms, seeking care or failing to seek care at all. Samples of women in Brent and Harrow were studied in antenatal, gynaecology, family planning, and GUM clinics, and in general practice. This comprehensive study took into account both multiple agencies, subsamples of non-consulters on general practitioner lists, and residents seeking care at STD clinics elsewhere in England, and thus gave a true population incidence and prevalence.

The authors recognise that there are limitations to their study from only sampling attenders at one clinic within Brent and Harrow, but they should not then make claims that infections occur along major transport routes, that there are sex differences among those with gonorrhoea and chlamydia, that the proportion of infected teenagers is small, and about the efficacy of male to female transmission and diagnostic tests. It is a shame that a study that could have formed the basis of important public health interventions within Brent and Harrow has, by its limited sampling, not been able to do so. The asymptomatic nature of many STDs, the fact that even those with symptoms do not always seek care, and that partner notification is not always as effective as one would desire, must mean that people with STDs within the community are potentially not identified by samples taken from clinic attenders. Public health strategy should be based on true population samples, and not limited to attenders at specialist clinics.

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Epidemiological treatment and tests of cure in gonococcal infection: evidence for value

In his otherwise excellent review article,[1] Chris Carne makes the classic mistake in his conclusions of quoting somewhat spurious percentages rather than absolute values. He says that 42·6% of treatment failures will be missed if tests of cure are not routinely performed on men with gonococcal infection. However, a closer look at these figures shows that out of the original 4897 men, only 183 (3·7%) were treatment failures, of whom only 78 (1·6%) were asymptomatic; therefore, only 78/4897 (1·6%) of the total would remain infected after treatment if a policy of test of cure for asymptomatic men were not followed; a more meaningful statistic. As Carne himself points out in the article, the cost of identifying each of these very small numbers of cases in America was estimated to be in the range $4900 to $109 800 per case. It might therefore be argued that a more cost effective use of this money would be to